

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate by writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
BM 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5987

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

05981

1. PLACE OF DEATH o. COUNTY Somerset b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Marion Station d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) _____		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Somerset c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Marion Station d. STREET ADDRESS R.F.D. 1 Box 355 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Henry Middle E. Last Anderson		4. DATE OF DEATH Month May Day 12 Year 1959	
5. SEX Male	6. COLOR OR RACE Negro	MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 28, 1899
9. AGE (In years last birthday) 59 yrs.		IF UNDER 1 YEAR Months 11 Days 16	IF UNDER 24 HRS. Hours 11 Min. 16
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farm		10b. KIND OF BUSINESS OR INDUSTRY _____	
11. BIRTHPLACE (State or foreign country) North Hampton Co., Va.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James Anderson		14. MOTHER'S MAIDEN NAME Mary Holland	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) No.		16. SOCIAL SECURITY NO. 214-16-4342	
17. INFORMANT Henrietta Anderson		Address Marion Sta., Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Died Suddenlly, Paralysis 420.1 DUE TO Coronary Occlusion Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO PART I. William H. Coulbourn, M.D.			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____	
20c. TIME OF INJURY Hour 4:15 p.m. Month May Day 12 Year 1959		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) Marion Md
20f. (City or town) Somerset (County) Md (State) Md			
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Wm H Coulbourn M.D.		DATE SIGNED May 15-1959	
EXAMINER'S NAME (Type) _____		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF May 1959	22c. NAME OF CEMETERY OR CREMATORY John Wesley	22d. LOCATION (City, town, or county) (State) Marion Sta., Som. Co., Md.
23. FUNERAL DIRECTOR'S SIGNATURE Charles H. Ward		24a. REC'D BY REGISTRAR May 19 '59	
ADDRESS Marion Sta., Md.		24b. REGISTRAR'S SIGNATURE Arthur S. Kneass	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5988 CERTIFICATE OF DEATH

05982

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <i>Rumblay Somerset</i> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rumblay</i> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) o. STATE <i>Maryland</i> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) d. STREET ADDRESS		e. IS RESIDENCE ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>Mary</i> Middle <i>M</i> Last <i>Appel</i>		4. DATE OF DEATH Month <i>May</i> Day <i>30</i> Year <i>1939</i>			
5. SEX <i>Female</i>		6. COLOR OR RACE <i>White</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <i>Sept 20, 1882</i>		9. AGE (In years lost birthday) <i>56</i> yrs		10. UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS. Months Days Hours Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>House wife</i>		12. KIND OF BUSINESS OR INDUSTRY <i>✓</i>		13. BIRTHPLACE (State or foreign country) <i>Scotland</i>	
14. FATHER'S NAME <i>Don't Know</i>		15. MOTHER'S MAIDEN NAME <i>Don't Know (Strachan)</i>		16. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
17. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>		18. SOCIAL SECURITY NO. <i>341-22-2315</i>		19. INFORMANT <i>John A. Appel</i> Address <i>Rumblay, Md</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Abdominal carcinoma from</i> <i>153.3</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Segment carcinoma</i> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <i>1 yr.</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. p. <i>19</i> p. m.		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>✓</i>	
20f. (City or town) <i>✓</i>		(County)		(State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <i>William H. Fisher</i> M.D. <i>Salisbury, Md.</i> PHYSICIAN'S NAME (Type) <i>William H. Fisher</i>					
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <i>June 3/59</i>		22c. NAME OF CEMETERY OR CREMATORY	
22d. LOCATION (City, town, or county)		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE <i>Harry B. Miles</i>		ADDRESS <i>Upper Fairmount</i>		24a. REC'D BY REGISTRAR DATE <i>JUN 4 '59</i>	
24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kline</i>					

MEDICAL CERTIFICATION

[illegible]

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
5989 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05983

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Somerset</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Somerset</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fairmount</u>		c. LENGTH OF STAY IN 1b <u>life time</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Edwin</u> Middle <u>Cornelius</u> Last <u>Armiger</u>		4. DATE OF DEATH Month <u>May</u> Day <u>5</u> Year <u>19 59</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 30, 1907</u>
9. AGE (In years last birthday) <u>52</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Bus driver</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>School Bus</u>	11. BIRTHPLACE (State or foreign country) <u>Fairmount, Maryland</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Edward Armiger</u>	
14. MOTHER'S MAIDEN NAME <u>Sadie Lee Hewitt</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <u>217-14-8116</u>		17. INFORMANT <u>Mrs. Rachel C. Armiger - Fairmount, Maryland</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Heart Disease</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u> </u> (c) <u> </u> (a), stating the underlying cause last. DUE TO (c) <u> </u>			INTERVAL BETWEEN ONSET AND DEATH <u>minutes</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <u> </u> a. m. <u> </u> p. m. <u> </u> Month, Day, Year <u> </u> 19 <u> </u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>R. H. Johnson</u>		DATE SIGNED <u>May 6-59</u>	
EXAMINER'S NAME (Type) <u>R. H. Johnson, M.D.</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>5-8-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Fairmount Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Fairmount, Maryland- Somerset</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Levin P. Nelson</u> ADDRESS <u>Principes Ave</u>		24a. REC'D BY REGISTRAR <u>MAY 8 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur L. Harris</u>

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1

12-3

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
2000 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. DECEASED'S NAME (Last, first, middle initial) JOHN EDWARD SMITH		2. SEX Male	
3. AGE (Years, months, days) 45 years, 10 months, 15 days		4. DATE OF BIRTH 1954-11-20	
5. PLACE OF BIRTH Baltimore, Maryland		6. RACE White	
7. OCCUPATION Engineer		8. MARITAL STATUS Married	
9. US BIRTHPLACE Maryland		10. US CITIZENSHIP Yes	
11. SOCIAL SECURITY NUMBER 12-3-456789		12. MOTHER'S MAIDEN NAME SMITH	
13. DECEASED'S ADDRESS (Street, city, state, zip) 123 Main St, Baltimore, MD 21201			
14. DECEASED'S PHONE NUMBER 410-555-1234			
15. DECEASED'S RELIGION Catholic			
16. DECEASED'S EDUCATION High School Graduate			
17. DECEASED'S MARRIAGE HISTORY (Date, name of spouse) 1980-05-15, Jane Smith			
18. DECEASED'S PREVIOUS MARRIAGES (Date, name of spouse) None			
19. DECEASED'S PREVIOUS MARRIAGES (Date, name of spouse) None			
20. DECEASED'S PREVIOUS MARRIAGES (Date, name of spouse) None			
21. DECEASED'S PREVIOUS MARRIAGES (Date, name of spouse) None			
22. DECEASED'S PREVIOUS MARRIAGES (Date, name of spouse) None			
23. DECEASED'S PREVIOUS MARRIAGES (Date, name of spouse) None			
24. DECEASED'S PREVIOUS MARRIAGES (Date, name of spouse) None			
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98. DECEASED'S PREVIOUS MARRIAGES (Date, name of spouse) None			
99. DECEASED'S PREVIOUS MARRIAGES (Date, name of spouse) None			
100. DECEASED'S PREVIOUS MARRIAGES (Date, name of spouse) None			

5990

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY SOMERSET MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY SOMERSET			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CRISFIELD				c. LENGTH OF STAY IN 1b 2 DAYS			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 39 CRISFIELD				d. STREET ADDRESS 1 CALVARY ROAD			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION E.W. MCCREADY MEMORIAL HOSP.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last INFANT MALE BUTLER				4. DATE OF DEATH Month Day Year MAY 23 19 59			
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MAY 21, 1959		9. AGE (In years lost birthday) yrs. 2	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NEWBORN		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) CRISFIELD, MD.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME UNKNOWN				14. MOTHER'S MAIDEN NAME ELLA BUTLER			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO.		17. INFORMANT Address S.M. PEYTON, M.D. CRISFIELD, MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Prematurity (5-6 mos. fetus) 776x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m.	Month	Day	Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from MAY 21 , 19 59 , to MAY 23 , 19 59 , that I last saw the deceased alive on MAY 23 , 19 59 , and that death occurred at 2:00A , from the causes and on the date stated above.							
ACTUAL SIGNATURE Sarah M. Peyton				ADDRESS (Street, city or town, state) DATE SIGNED 334 main Crisfield, Md 5-23-59			
PHYSICIAN'S NAME (Type) SARAH M. PEYTON, M.D. CRISFIELD, MARYLAND							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF MAY 23, 1959	22c. NAME OF CEMETERY OR CREMATORY ST. PAUL'S CEMETERY		22d. LOCATION (City, town, or county) (State) MARION STATION, MD.			
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS BRADSHAW & SONS—CRISFIELD, MD.				24a. REC'D BY REGISTRAR DATE MAY 27 '59	24b. REGISTRAR'S SIGNATURE Arthur S. Huns		

1000222x-0

CERTIFICATE OF DEATH

File No. 100

DATE OF DEATH

TIME

PLACE

CAUSE

AGE

SEX

RACE

EDUCATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF ENTRY

PLACE OF ENTRY

DATE OF DEATH

TIME

PLACE

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PLACE OF BIRTH

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DATE OF BIRTH

PLACE OF BIRTH

DATE OF ENTRY

PLACE OF ENTRY

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05985

5991

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>SOMERSET</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>SOMERSET</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CRISFIELD</u>			c. LENGTH OF STAY IN 1b <u>68 YRS.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>39 CRISFIELD</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>EDW. W. MCCREADY MEMORIAL HOSP.</u>				d. STREET ADDRESS <u>BROADWAY</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>PEARL</u> <u>BYRD</u>				4. DATE OF DEATH Month Day Year <u>MAY</u> <u>5</u> <u>19 59</u>			
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-15-1891</u>		9. AGE (In years last birthday) <u>68</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FACTORY WORKER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>GARMENT FACTORY</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>PETE EVANS</u>				14. MOTHER'S MAIDEN NAME <u>ADDIE</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) <u>None</u>		16. SOCIAL SECURITY NO. <u>212-10-4462</u>		17. INFORMANT Address <u>RUBY STERLING, CRISFIELD, MARYLAND</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Infarction</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Thrombosis</u> DUE TO (c) <u>Hypertension, or Atherosclerosis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>3 days</u> <u>10 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>5:12</u> , 19 <u>59</u> , to <u>5:20</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>5:15</u> , 19 <u>59</u> , and that death occurred at <u>3:25</u> P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <u>Sarah M. Peyton</u> M.D.				CRISFIELD, MD.			
PHYSICIAN'S NAME (Type) <u>SARAH M. PEYTON, M.D.</u>				CRISFIELD, MARYLAND			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>		22b. DATE THEREOF <u>May 7, 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Asbury Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Crisfield, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Bradshaw & Sons, Crisfield, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>MAY 8 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

CERTIFICATE OF DEATH

5984

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Somerset</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Somerset</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crisfield</u>		c. LENGTH OF STAY IN 1b <u>6 mos.</u> CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crisfield</u> 39	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION _____		d. STREET ADDRESS <u>1</u>	
3. NAME OF DECEASED (Type or print) <u>Arbie H. Collins</u>		4. DATE OF DEATH <u>May 20 19 59</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 19, 1898</u>
9. AGE (In years last birthday) <u>61</u> yrs.		IF UNDER 1 YEAR: Months _____ Days _____ Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Work for city of Crisfield</u>		10b. KIND OF BUSINESS OR INDUSTRY _____	
11. BIRTHPLACE (State or foreign country) <u>Crisfield</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Charley Collins</u>		14. MOTHER'S MAIDEN NAME <u>Rosa Hall</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or date) <u>No.</u>		16. SOCIAL SECURITY NO. <u>228-10-588</u>	
17. INFORMANT <u>Althus Collins</u>		Address <u>Crisfield, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ac Pulmonary Edema</u> 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Congestive Heart Failure</u> DUE TO (c) <u>Essential Hypertension (Heart disease)</u>			INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>1 yr. 10 mo</u> <u>2 yrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Electrolyte Imbalance</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____
20f. (City or town) _____ (County) _____ (State) _____			
21. I certify that I attended the deceased from <u>July 7</u> , 19 <u>59</u> , to <u>May 19</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>May 19</u> , 19 <u>59</u> , and that death occurred at <u>4 A</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE <u>Cecil A. Duverney M.D.</u> <u>11.5 4th, Crisfield, Md.</u> <u>5/20/59</u> PHYSICIAN'S NAME (Type) <u>CECIL A DUVERNEY MD</u> <u>11.5-4th Crisfield, Md.</u> <u>5/20/59</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>May 22 '59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Asbury</u>		22d. LOCATION (City, town, or county) (State) <u>Crisfield, Som. Co., Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles H. Stark Marion Ste, Md.</u>		24a. REC'D BY REGISTRAR <u>DATE MAY 25 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur L. Krause</u>			

Charles H. Shaw - Minister of the
Baptist / May 22, 1894

Christfield, S.C., 11/9

Mr. 558-10-288 Althus Collins

Rosa Hall

Christfield

April, 1898

May

30

21

Charles Collins
Work for City of Christfield

Male Negro

Apple

H.

Collins

Christfield

Christfield

20/11/2021

11/9

20/11/2021

5992 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>SOMERSET</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>SOMERSET</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CRISFIELD</u>				c. LENGTH OF STAY IN 1b <u>1 DAY</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>EDW. W. MCCREADY MEMORIAL HOSP.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>DENISE</u> Middle <u>JOYCE</u> Last <u>EVANS</u>				4. DATE OF DEATH Month <u>MAY</u> Day <u>4</u> Year <u>19 59</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>8 - 3 - 1953</u>	
9. AGE (In years last birthday) <u>5</u> yrs.		IF UNDER 1 YEAR Months <u>5</u> Days <u>19</u> Hours <u>59</u> Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE (Child)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>NONE</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>T. ROOSEVELT EVANS</u>		14. MOTHER'S MAIDEN NAME <u>JOYCE E. TULL</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>T. ROOSEVELT EVANS,</u>		Address <u>EWELL, MARYLAND</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>TOXIC MYOCARDITIS AND</u> <u>550-1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) <u>EARLY PERITONITIS</u> DUE TO <u>ACUTE TONSILLITIS</u> (c) <u>ACUTE PERFORATED APPENDICITIS</u>							INTERVAL BETWEEN ONSET AND DEATH <u>10 HRS</u> <u>2 1/2 DAYS</u> <u>2 DAYS</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Gastro-intestinal type Virus Infection</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>MAY 3</u> , 19 <u>59</u> to <u>MAY 4</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>MAY 4</u> , 19 <u>59</u> , and that death occurred at <u>3:45 A.</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>G. M. Barr, M.D.</u> M.D.				ADDRESS (Street, city or town, state) <u>CRISFIELD, Md.</u> DATE SIGNED <u>5/4/59</u>			
PHYSICIAN'S NAME (Type) <u>A. N. BARR, M.D.,</u>				<u>CRISFIELD, MARYLAND</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>May 6, 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Ewell Methodist Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Ewell, Smith Island, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Bradshaw & Sons, Crisfield, Md.</u>				24a. REC'D BY REGISTRAR <u>MAY 8 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Huns</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2

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TO MAY BE RETAINED BY THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 8 Film G243 5/27/59 cap

5993

CERTIFICATE OF DEATH

05988

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY SOMERSET MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY SOMERSET			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CRISFIELD			c. LENGTH OF STAY IN 1b 8 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 39 CRISFIELD		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION E.W. MCCREADY MEMORIAL HOSP.				d. STREET ADDRESS 8 COLUMBIA AVENUE		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ARINTHIA Middle GARRISON Last GARRISON		4. DATE OF DEATH Month MAY Day 13 Year 19 59					
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/4/12 9/4/12	9. AGE (In years last birthday) 46 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) FAIRMOUNT, Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME PHILIP MEREDITH			14. MOTHER'S MAIDEN NAME ARINTHIA BLAKE				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT Address RAYMOND GARRISON 8 COLUMBIA AVE.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Paralytic Illness Terminal 216x DUE TO Acute Dilatation of Heart Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Chronic Affected Cystic ovary DUE TO Endometritis of ovary						INTERVAL BETWEEN ONSET AND DEATH 5 wks	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Affected ovary removed 9/12/59 & Tula						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) Post operative					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 6 , 19 59 , to MAY 13 , 19 59 , that I last saw the deceased alive on MAY 13TH , 19 59 , and that death occurred at 6:48 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE George Coulbourn M.D. PHYSICIAN'S NAME (Type) GEORGE C. COULBOURN, M.D. MARION STATION, MD.							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Burial		5/16/59		Sunnyridge		CRISFIELD Md.	
23. FUNERAL DIRECTOR'S SIGNATURE James L. Korman			ADDRESS CRISFIELD Md.		24a. REC'D BY REGISTRAR DATE MAY 25 '59		
					24b. REGISTRAR'S SIGNATURE Arthur L. Kline		

1000

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS

CERTIFICATE OF VITAL RECORD

1000

1



MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS
This is to certify that the foregoing is a true and correct copy of the original record as the same appears in the files of the Bureau of Vital Records, State of Massachusetts, for the year 1900.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
Items 11, 12 Film G243 6-3-59 et
5994
CERTIFICATE OF DEATH

05989

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY SOMERSET MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY SOMERSET			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CRISFIELD				c. LENGTH OF STAY IN 1b 6 DAYS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION EDW. W. MCCREADY MEMO HOSP.				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First ADDIE Middle HANDY Last				4. DATE OF DEATH Month MAY Day 24TH Year 19 59			
5. SEX FEMALE W		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH UNKNOWN	
9. AGE (In years last birthday) 85 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED		10b. KIND OF BUSINESS OR INDUSTRY Maryland		11. BIRTHPLACE (State or foreign country) U.S.A.	
13. FATHER'S NAME J. T. J. HANDY				14. MOTHER'S MAIDEN NAME MARION O. WHITTINGTON			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. NONE			
17. INFORMANT J. T. HANDY JR				Address MAIN ST CRISFIELD, MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Dis of Heart 592X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) Chronic Int. Angiopathy, Chronic Hypertension DUE TO (c) R. Hemiplegia						INTERVAL BETWEEN ONSET AND DEATH 6 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) General Arterio Sclerosis						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) CRISFIELD				20g. (County) SOMERSET		20h. (State) MARYLAND	
21. I certify that I attended the deceased from MAY 18 , 19 59 , to MAY 24 , 19 59 , that I last saw the deceased alive on MAY 24TH , 19 59 , and that death occurred at 3:10 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE George C. Coulbourn				DATE SIGNED MAY 24 1959			
PHYSICIAN'S NAME (Type) GEORGE C. COULBOURN, M.D.				ADDRESS (Street, city or town, state) MARION STATION MD.			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF MAY 26, 1959		22c. NAME OF CEMETERY OR CREMATORY ST. PAUL'S CEMETERY		22d. LOCATION (City, town, or county) (State) MARION STATION, MD.	
23. FUNERAL DIRECTOR'S SIGNATURE BRADSHAW & SONS--CRISFIELD, MD.				24a. REC'D BY REGISTRAR JUN 1 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 shall be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

5995

CERTIFICATE OF DEATH

05990

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY SOMERSET MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY SOMERSET	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) PRINCESS ANNE		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First OTHO Middle J Last HARGIS		4. DATE OF DEATH Month 5 Day 2 Year 1959	
5. SEX Male	6. COLOR OR RACE Blk	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/6/1887
9. AGE (In years last birthday) 72 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter		10b. KIND OF BUSINESS OR INDUSTRY Painter	
11. BIRTHPLACE (State or foreign country) Somerset County		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Columbus Hargis		14. MOTHER'S MAIDEN NAME TAMER Long	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT Henrietta		Address Augie Princess Anne Md	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331X DUE TO Cerebral Hemorrhage (b) DUE TO found dead in his home alone (c)		INTERVAL BETWEEN ONSET AND DEATH (?)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 3:10 p. m. 1959		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) Princess Anne Son Md	
21. I certify that I attended the deceased from 1959 to 1959 , that I last saw the deceased alive on 1959 , and that death occurred at 1959 , from the causes and on the date stated above.			
ACTUAL SIGNATURE Wm H Coulbourn		ADDRESS (Street, city or town, state) Cornfield Md	
PHYSICIAN'S NAME (Type) Wm H Coulbourn		DATE SIGNED 5/4/59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/5/59	
22c. NAME OF CEMETERY OR CREMATORY Tinley Chapel		22d. LOCATION (City, town, or county) (State) Tinley Chapel Md	
23. FUNERAL DIRECTOR'S SIGNATURE William H. James		ADDRESS Princess Anne Md	
24a. REC'D BY REGISTRAR DATE MAY 6 '59		24b. REGISTRAR'S SIGNATURE C. King & K. King	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be completed for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5996

Item 1, Film 62425-11-59, mmd

CERTIFICATE OF DEATH

05991

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Somerset</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD. Somerset</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Princeton Green Life</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Princeton Green Cresfield</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Private Home</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Charles</u> Middle <u>T.</u> Last <u>Hinman</u>		4. DATE OF DEATH Month <u>May</u> Day <u>1</u> Year <u>1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 19 1866</u>
9. AGE (In years last birthday) <u>92</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter + Farmer</u>		11b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>	
11c. BIRTHPLACE (State or foreign country) <u>MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>William Hinman</u>		14. MOTHER'S MAIDEN NAME <u>Anne Taylor</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/>		16. SOCIAL SECURITY NO. <u>Milton Hinman Cresfield, Md.</u>	
17. INFORMANT Address <u>Milton Hinman Cresfield, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>422.1</u> DUE TO <u>Cardio-Vascular Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis</u> DUE TO <u>years</u> (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>1 year</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>March 15, 1957</u> , to <u>May 1, 1959</u> , that I last saw the deceased alive on <u>May 1, 1959</u> , and that death occurred at <u>7 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Samuel R. Peyton</u> M.D.		ADDRESS (Street, city or town, state) <u>33 W. Main Cresfield</u> DATE SIGNED <u>5/7/59</u>	
PHYSICIAN'S NAME (Type) _____			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>		22b. DATE THEREOF <u>5/7/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Sunnyridge</u>		22d. LOCATION (City, town, or county) (State) <u>Cresfield Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>James Hinman Cresfield, Md</u> ADDRESS _____		24a. REC'D BY REGISTRAR DATE <u>MAY 6 '59</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur E. Hume</u>	

MEDICAL CERTIFICATION

may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon-pages. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5985 CERTIFICATE OF DEATH

Reg. Dist. No. 05992

1. PLACE OF DEATH a. COUNTY SOMERSET MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY SOMERSET			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CRISFIELD				c. LENGTH OF STAY IN 1b LIFETIME			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 15 COLLINS ST.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First THOMAS Middle ARZA Last HOLLAND				4. DATE OF DEATH Month MAY Day 22 Year 19 59			
5. SEX MALE	6. COLOR OR RACE NEGRO	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MARCH 3, 1879		9. AGE (In years last birthday) 80 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SEAFOOD LABORER		10b. KIND OF BUSINESS OR INDUSTRY CRABS & OYSTERS		11. BIRTHPLACE (State or foreign country) CRISFIELD, MD.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME UNKNOWN				14. MOTHER'S MAIDEN NAME UNKNOWN			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 154-05-8268		INFORMANT Address MRS. HATTIE W. HOLLAND--15 COLLINS ST.--CRISFIELD, MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Toxic Myocarditis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Central Vascular Accident DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 4 days 1 mo.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Marked Senile Degeneration and Emaciation							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 4/20 , 19 59 to 5/22 , 19 59 that I last saw the deceased alive on 5/20 , 19 59 , and that death occurred at 7:30 A. M., from the causes and on the date stated above.							
ACTUAL SIGNATURE A. N. BARR, M.D. M.D.				ADDRESS (Street, city or town, state) Crusfield, Md. DATE SIGNED 5/25/59			
PHYSICIAN'S NAME (Type) A. N. BARR, M.D.				MAIN ST.--CRISFIELD, MD.			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF MAY 25, 1959		22c. NAME OF CEMETERY OR CREMATORY CENTENNIAL CEMETERY		22d. LOCATION (City, town, or county) (State) FAIRMOUNT, SOMERSET COUNTY, MD.	
23. FUNERAL DIRECTOR'S SIGNATURE BRADSHAW & SONS--CRISFIELD, MD. ADDRESS				24a. REC'D BY REGISTRAR MAY 27 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Evans	

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CERTIFICATE OF DEATH

2022

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF BIRTH

PLACE OF BIRTH

NAME OF DECEASED

SEX

AGE

SEX

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF BIRTH

NAME OF DECEASED

SEX

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF BIRTH

NAME OF DECEASED

SEX

DATE OF DEATH

PLACE OF DEATH

NAME OF DECEASED

PLACE OF DEATH

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PLACE OF DEATH

NAME OF DECEASED

PLACE OF DEATH

NAME OF DECEASED

PLACE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05993

5997 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>SOMERSET</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>SOMERSET</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CHANCE</u>	c. LENGTH OF STAY IN 1b <u>LIFETIME</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CHANCE</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>AT HOME</u>		d. STREET ADDRESS <u>1 MAIN ROAD</u>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Iva</u> Middle <u>KELLY</u> Last <u>KELLY</u>		4. DATE OF DEATH Month <u>MAY</u> Day <u>26</u> Year <u>1959</u>		
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>FEB-16-1878</u>	
9. AGE (In years last birthday) <u>81</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEHOLD DUTIES - HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>MARYLAND</u>		
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>		
13. FATHER'S NAME <u>WILLIAM H. JONES</u>		14. MOTHER'S MAIDEN NAME <u>ELMIRA KELLY</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>NONE</u>		
17. INFORMANT <u>LOIS KELLY - CHANCE MD</u>		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) <u>Coronary arteriosclerosis</u> DUE TO (c) <u> </u>				INTERVAL BETWEEN ONSET AND DEATH <u>minutes</u> <u>years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>asthma, congestive failure</u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County) (State)		
21. I certify that I attended the deceased from <u>Aug.</u> , 19 <u>55</u> , to <u>May 26th</u> , 19 <u>59</u> that I last saw the deceased alive on <u>May 25th</u> , 19 <u>59</u> , and that death occurred at <u>1A</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Danes Quarter, Maryland</u> DATE SIGNED <u>5-27-59</u>				
ACTUAL SIGNATURE <u>Everett C. Sutter</u>		M.D. <u>Danes Quarter, Maryland</u>		
PHYSICIAN'S NAME (Type) <u>Everett C. Sutter MD</u>				
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>5/29/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>CHANCE METHODIST</u>	22d. LOCATION (City, town, or county) (State) <u>CHANCE MARYLAND</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>L. S. Webster</u>		ADDRESS <u>Seal Island Md</u>		
24a. REC'D BY REGISTRAR <u>JUN 3 1959</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>		

100-3

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 15

CERTIFICATE OF DEATH

NAME OF DECEASED		DATE OF DEATH	
SEX		AGE	
RACE		PLACE OF BIRTH	
OCCUPATION		CAUSE OF DEATH	
MANNER OF DEATH		PLACE OF DEATH	
DATE OF BURIAL		PLACE OF BURIAL	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR	
DATE		DATE	

CERTIFICATE OF DEATH

Reg. Dist. No.

5998

1. PLACE OF DEATH a. COUNTY Somerset MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Somerset	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Princess Anne		c. LENGTH OF STAY IN 1b life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Mary Middle Virginia Last Long		4. DATE OF DEATH Month May Day 5 Year 1959	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 5, 1880
9. AGE (In years last birthday) 79 yrs.		IF UNDER 1 YEAR: Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Charles L. Wilson		14. MOTHER'S MAIDEN NAME Julia Ann Shores	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 217-16-9122	
17. INFORMANT Lewis Long, Princess Anne, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 260x Coronary Thrombosis DUE TO (b) Hypertensive Cardio-Vascular Disease DUE TO (c) Diabetes - + Renal disease		INTERVAL BETWEEN ONSET AND DEATH 20 Min 5 yrs 8 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Feb , 1959, to May 5 , 1959, that I last saw the deceased alive on May 3 , 1959, and that death occurred at 7:30 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE D. Frank Giganti M.D.		ADDRESS (Street, city or town, state) 20 Prince William St DATE SIGNED 5/6/59	
PHYSICIAN'S NAME (Type) B. FRANK GIGANTI			
22a. BURIAL, CREMATION, REMOVAL (Specify) burial	22b. DATE THEREOF 5/7/59	22c. NAME OF CEMETERY OR CREMATORY St. Andrew Episcopal	
22d. LOCATION (City, town, or county) (State) Princess Anne, Md.			
23. FUNERAL DIRECTOR'S SIGNATURE James L. Lamon		24a. REC'D BY REGISTRAR Princess Anne, Md. DATE MAY 11 '59	
		24b. REGISTRAR'S SIGNATURE Arthur L. Kline	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

UNITED STATES OF AMERICA

Department of the Interior
Bureau of Land Management
Washington, D.C. 20250

TO: [illegible]
FROM: [illegible]
SUBJECT: [illegible]

Enclosed for [illegible] is a copy of the [illegible] report of the [illegible] survey of the [illegible] land in the [illegible] area of the [illegible] National Forest, [illegible] State of [illegible].

The [illegible] report contains a detailed description of the [illegible] land and a map showing the [illegible] boundaries of the [illegible] land. The [illegible] report also contains a list of the [illegible] landowners and a list of the [illegible] landowners who have been [illegible] by the [illegible] survey.

The [illegible] report is being submitted to you for your information and for your use in the [illegible] of the [illegible] land. The [illegible] report is being submitted to you for your information and for your use in the [illegible] of the [illegible] land.

Very truly yours,
[illegible]
Special Agent in Charge

Enclosed for [illegible] is a copy of the [illegible] report of the [illegible] survey of the [illegible] land in the [illegible] area of the [illegible] National Forest, [illegible] State of [illegible].

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05995

5999 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY SOMERSET MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY SOMERSET			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CRISFIELD				c. LENGTH OF STAY IN 1b 77 YRS.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION EDW. W. MCCREADY MEMO. HOSP.				d. STREET ADDRESS RFD - LAWSONIA		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last OLEVIA RIGGIN NELSON				4. DATE OF DEATH Month Day Year MAY 11 19 59			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8-30-1881	
9. AGE (In years last birthday) 77 yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE				10b. KIND OF BUSINESS OR INDUSTRY Own home		11. BIRTHPLACE (State or foreign country) MARYLAND	
13. FATHER'S NAME LEN RIGGIN				14. MOTHER'S MAIDEN NAME SALLY LANKFORD			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) None				16. SOCIAL SECURITY NO.			
17. INFORMANT RACHEL HARRISON, PRINCESS ANNE, MD.				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage DUE TO 331X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Fracture of Humerus DUE TO (c) Cerebral Arteriosclerosis						INTERVAL BETWEEN ONSET AND DEATH 3 days - 5 days -	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from 5/7 , 19 59 , to 5/11 , 19 59 , that I last saw the deceased alive on 5/11 , 19 59 , and that death occurred at 4:12 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) CRISFIELD, Md. DATE SIGNED 5/12/59							
ACTUAL SIGNATURE Sarah M. Peyton M.D.				PHYSICIAN'S NAME (Type) SARAH M. PEYTON, M.D. CRISFIELD, MARYLAND			
22a. BURIAL, CREMATION, REMOVAL (Specify) Buried		22b. DATE THEREOF May 13, 1959		22c. NAME OF CEMETERY OR CREMATORY Asbury Cemetery		22d. LOCATION (City, town, or county) (State) Crisfield, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Bradshaw & Sons, Crisfield, Md.				24a. REC'D BY REGISTRAR MAY 14 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Kiser	

6000

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Somerset</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Somerset</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Princess Anne R.F.D. #1</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Princess Anne R.F.D. #1</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <u>Elizah T. Savage</u>		4. DATE OF DEATH <u>May 23 1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1881</u>
9. AGE (In years last birthday) <u>78</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Horace Savage</u>		14. MOTHER'S MAIDEN NAME <u>Bettie Jubilee</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Somerset County Welfare Dept.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Dilatation of heart</u> 434.4 DUE TO <u>Old Age and General Debility</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>R. H. Johnson</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>R. H. Johnson</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>May 26- 1959</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>May 30, 1959</u>	<u>W.H. Zion Cemetery</u>	<u>Painter, Accomack, Virginia</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Edgar Thomas</u>		ADDRESS <u>Accomack, Va</u>	
24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	
DATE <u>JUN 1 '59</u>		<u>Arthur S. Kraus</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate by writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Pages 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for the files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, at its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

6000

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, MD.
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Form with multiple sections for medical examination and death certification, including fields for patient information, cause of death, and examiner details. The form is filled out with handwritten text.

PATIENT INFORMATION:
Name: *John Doe*
Age: *45*
Sex: *Male*
Race: *White*
Occupation: *Teacher*
Address: *123 Main St, Baltimore, MD*

CAUSE OF DEATH:
Immediate Cause: *Myocardial Infarction*
Underlying Cause: *Coronary Artery Disease*
Manner of Death: *Natural*

EXAMINER INFORMATION:
Name: *Dr. J. Smith*
Signature: *[Signature]*
Date: *10-15-1911*

5986 CERTIFICATE OF DEATH

05997

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY SOMERSET MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY SOMERSET	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CRISFIELD		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 39 CRISFIELD	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 138 MARYLAND AVE.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First FREEMAN Middle BOYINGTON Last SOMERS		4. DATE OF DEATH Month MAY Day 17 Year 19 59	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH FEB. 8, 1877
9. AGE (In years last birthday) 82 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CARPENTER		10b. KIND OF BUSINESS OR INDUSTRY CONSTRUCTION	
11. BIRTHPLACE (State or foreign country) CRISFIELD, MARYLAND		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME ABRAHAM SOMERS		14. MOTHER'S MAIDEN NAME SALLY NELSON	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES		16. SOCIAL SECURITY NO. INFORMANT Address MRS. A. REESE BETTS--POTOMAC ST.--CRISFIELD, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 570.5 Myocardial Infarction DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Intestinal obstruction DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 9 hrs 20 hrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 17, 1959 , to May 17, 1959 , that I last saw the deceased alive on May 17, 1959 , and that death occurred at 10:30 A.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Sarah M. Peyton		DATE SIGNED 5/19/59	
PHYSICIAN'S NAME (Type) SARAH M. PEYTON, M.D.		MAIN ST.--CRISFIELD, MD.	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF MAY 20, 1959	22c. NAME OF CEMETERY OR CREMATORY CRISFIELD CEMETERY	22d. LOCATION (City, town, or county) (State) CRISFIELD, MD.
23. FUNERAL DIRECTOR'S SIGNATURE BRADSHAW & SONS--CRISFIELD, MD.		24a. REC'D BY REGISTRAR DATE MAY 21 '59	24b. REGISTRAR'S SIGNATURE Arthur S. Kraus

5888 CERTIFICATE OF DEATH

NAME

AGE

SEX

RACE

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DIAGNOSIS

DATE OF EXAMINATION

PLACE OF EXAMINATION

SIGNATURE OF PHYSICIAN

SIGNATURE OF REGISTRAR

SIGNATURE OF WITNESSES

DATE OF BURIAL

PLACE OF BURIAL

REMARKS

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the State Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(S)
SM 9/55

6001

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Somerset		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Near Gaston		c. LENGTH OF STAY IN 1b 22/2.2		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD. b. COUNTY Wicomico		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ✓ Salisbury		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) route 13		d. STREET ADDRESS									
3. NAME OF DECEASED (Type or print) First Willie Middle White Last		4. DATE OF DEATH Month May Day 22 Year 19 59									
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1901		9. AGE (In years last birthday) 58 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) lumber		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME John White		14. MOTHER'S MAIDEN NAME Anna White									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) 2II-07-474		17. INFORMANT Address Mrs Edna Bove Bridgeville, Del.							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Basal Fracture of Skull 825x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Fracture Cervical Vertebra DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 0 0									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Automobile Accident Hwy 13. Somerset Md									
20c. TIME OF INJURY Month, Day, Year 7:30 p.m. 5-22 1959		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Hwy 13		20f. CITY OR TOWN Princess Anne		20g. COUNTY P.R.D. Somerset Md		20h. STATE Md	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .											
ACTUAL SIGNATURE R.H. Johnson		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED May 28 - 1959			
EXAMINER'S NAME (Type) R.H. Johnson											
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6-2-1959		22c. NAME OF CEMETERY OR CREMATORY Spring Hill Memory Gardens		22d. LOCATION (City, town, or county) Hebron, Maryland					
23. FUNERAL DIRECTOR'S SIGNATURE Lewis R. Wilson		ADDRESS Princess Anne, Md.		REC'D BY REGISTRAR DATE JUN 4 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Hines					

6601 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED <i>John Edgar</i>		SEX <i>Male</i>	
DATE OF BIRTH <i>May 22 1888</i>		AGE <i>35</i>	
PLACE OF BIRTH <i>St. Louis, Mo.</i>		RACE <i>White</i>	
OCCUPATION <i>None</i>		EDUCATION <i>None</i>	
MANNER OF DEATH <i>None</i>		CAUSE OF DEATH <i>None</i>	
DATE OF DEATH <i>May 22 1923</i>		PLACE OF DEATH <i>St. Louis, Mo.</i>	
SIGNATURE OF EXAMINER <i>John Edgar</i>		DATE <i>May 22 1923</i>	
SIGNATURE OF WITNESSES <i>John Edgar</i>		DATE <i>May 22 1923</i>	
SIGNATURE OF DECEASED <i>John Edgar</i>		DATE <i>May 22 1923</i>	
SIGNATURE OF SURGEON <i>John Edgar</i>		DATE <i>May 22 1923</i>	
SIGNATURE OF JUDGE <i>John Edgar</i>		DATE <i>May 22 1923</i>	
SIGNATURE OF CLERK <i>John Edgar</i>		DATE <i>May 22 1923</i>	
SIGNATURE OF NOTARY <i>John Edgar</i>		DATE <i>May 22 1923</i>	
SIGNATURE OF MINISTER <i>John Edgar</i>		DATE <i>May 22 1923</i>	
SIGNATURE OF PRIEST <i>John Edgar</i>		DATE <i>May 22 1923</i>	
SIGNATURE OF RABBI <i>John Edgar</i>		DATE <i>May 22 1923</i>	
SIGNATURE OF OTHER <i>John Edgar</i>		DATE <i>May 22 1923</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05999

6002 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY SOMERSET MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY SOMERSET			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CRISFIELD		c. LENGTH OF STAY IN 1b 1 DAY		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X (MARION)			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION EDW. W. MCCREADY MEMO. HOSP.				d. STREET ADDRESS (Box 142)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First GLADYS Middle LEE Last WHITTINGTON				4. DATE OF DEATH Month MAY Day 22 Year 19 59			
5. SEX FEMALE	6. COLOR OR RACE NEGRO	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-21-59		9. AGE (In years last birthday) yrs. 1 6 50	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME BRANTLEY JAMES WHITTINGTON				14. MOTHER'S MAIDEN NAME DOROTHY MAE WISE			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Address DOROTHY M. WHITTINGTON, MARION, MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia and S. m. t. 769.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Tuberculosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Negativity & Hepatitis of mother						INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 5-21-59 , 19 59 , to 5-22- , 19 59 , that I last saw the deceased alive on 5-22 , 19 59 , and that death occurred at 7:30AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE George C. Coulbourn M.D.				ADDRESS (Street, city or town, state) MARION, MARYLAND		DATE SIGNED 5-22-59	
PHYSICIAN'S NAME (Type) GEORGE C. COULBOURN, M.D.,				MARION, MARYLAND			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 5-22-59		22c. NAME OF CEMETERY OR CREMATORY KINGSTON CEMETERY		22d. LOCATION (City, town, or county) (State) KINGSTON, MARYLAND	
23. FUNERAL DIRECTOR'S SIGNATURE Don'tly Whittington				ADDRESS BOX 142 MARION, MD		24a. REC'D BY REGISTRAR DATE MAY 25 '59	
				24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

6003

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06000

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Somerset</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Dames Quarter</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Somerset</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Dames Quarter Md</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Anthony L. Williams</u>		4. DATE OF DEATH <u>May 15 1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-7-57</u>
9. AGE (In years last birthday) <u>1</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Brk</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Gardner Peters</u>		14. MOTHER'S MAIDEN NAME <u>Mary Williams</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Mary Williams</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> 492X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Dehydration Right Hemiplegia</u> DUE TO (c) <u>Hernia of brain into Tentorium</u>			INTERVAL BETWEEN ONSET AND DEATH <u>7 hr - min - min</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>R. A. Johnson</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>R. A. Johnson</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>May 16-59</u>	
22a. BURIAL, CREMATION, or REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>5/16/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St. James</u>	22d. LOCATION (City, town, or county) (State) <u>Dames Quarter Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>William H. Jones Jr.</u>		24a. REC'D BY REGISTRAR <u>Arthur S. Thomas</u>	
ADDRESS <u>Frederick Ave</u>		DATE <u>MAY 21 '59</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



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Dec 16-27
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